DOCUMENT RESUME

ED 301 837 CG 021 325

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TITLE Identity as Counseling Psychologists and Contexts for Training: The Choice at Hand.
PUB DATE Aug 88
NOTE 35p.; Paper presented at the Annual Meeting of the American Psychological Association (96th, Atlanta, GA, August 12-16, 1988).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Counseling Theories; *Counselors; *Counselor Training; Prevention; *Trend Analysis
IDENTIFIERS *Counseling Psychology; Identity Formation

ABSTRACT

This document presents an analysis of the identity of counseling psychology derived from the Greyston Conference in 1964 compared to current identity questions which were the focus of the Georgia Conference in 1987. The paper outlines what appears to be a major shift from counseling psychology based in schools, colleges, and career education centers to a focus on psychotherapy. The difficulties with this thrust are detailed as well as a rationale for counseling psychology to emphasize preventive and developmental theory and practice. It is suggested that counseling psychologists can continue to seek accommodation with clinical psychology and move into the practitioner and provider of health services model under the ageis of medicine, or they may go back to the roots of counseling psychology and add to the growing body of theory and practice evident in the past 20 years. The document concludes that it is time for counseling psychologists to deal with causes and not symptoms, to redirect efforts toward a distinctive identity as counseling psychologists, and to leave therapy to practitioners. (ABL)

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Identity as counseling psychologists and contexts for training: The choice at hand

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APA Conference
Atlanta, GA., August 1988

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Abstract

The paper presents an analysis of the identity of counseling psychology derived from the Greyston Conference in 1964 compared to current identity questions which were the focus of the Georgia Conference in 1987. The paper outlines what appears to be a major shift from counseling psychology based in schools, colleges and career education centers to a focus on psychotherapy. The difficulties with this thrust are detailed as well as a rationale for counseling psychology to emphasize preventive and developmental theory and practice.

History

If I were to run the clock back some twenty-three years and address the question at hand, e.g. Identity and the context for training, from the perspective of the Greyston Conference, both the rationale and thrust of my comments would be considerably different. It is most instructive to examine that conference from today's perspective since it tells so much about what has changed. Particularly, that we currently face questions which in many instances are totally different. Negative French existentialists often use the expression, "Plus ca change, plus c'est la meme chose," (the more things change, the more things are the same). In reviewing Greyston, we have to revise that expression to "Plus ca change, plus ca change," (the more things change, the more things change). It is my thesis that such major changes in the past one-quarter of a century have created both the identity question and the training site question which we now at long last confront. As well, it will be my thesis to point out that we have drifted, slowly at first and more rapidly, recently, into our present paradoxical position, which begs for resolution. Before I detail my reasons for such a view, however, I do wish to step back and review the identity of counseling psychology from a twenty-five perspective.

The Greyston Identity

If I had been so bold, as one of the youngest and newest member of Division 17, to raise the identity question at that Conference, what would have been the answer? Probably astonishment at the question, I'm sure that the leaders would have pointed out that counseling psychology and the allied fields of career development, college student personnel and school guidance were a generic core of theory and practice, in Jack Darley's words a "tolerable consensus" of courses and training experiences designed to foster professional growth. The work settings were obvious, schools, colleges, and vocational counseling centers. The thrust was equally obvious, the assessment of client strengths and the creation of programs through individual and group counseling to promote development for such clients in the three types of setting. In fact, if there was one message which the conference emphasized, it was the distinctions between generic counseling psychology (life span psychological and career development) and clinical psychology.

If I had asked about clinical psychology, the answer would have been quick and definitive. In the temperate language of the Report (Thompson & Super, 1964). I would have heard phrases such as, counseling psychology, "Then leaves to other psychologists the major

responsibility for emergency treatment of psychological disasters" (1964, p. 136), or - "Does not place special emphasis upon the development of tools and techniques necessary for intensive psychology" (1964, p. 136), or - "has less preoccupation with the use of psychological tests of the analysis of the individual's inner life" (1964, p. 137). Just imagine an Art Brayfield, David Tiedeman or a Leona Tyler answering a query about the Psychiatric "rosetta stone" DSM III as a diagnostic tool. Also, operationally, I would have been told that the overlap in membership between Div. 17 and 12 had dropped from 25% in 1957 to about 18% in 1961 and would be "less as the years pass" (1964, p. 154). The reason, counseling psychology was in the midst of its own identity development stage and, in fact, only 6% of our Division 17 members would classify themselves as clinical psychologists. In fact, the report summarized our position as follows:

"Most counseling psychologists...are employed in educational institutions... They do <u>not</u> call themselves clinical psychologists or school psychologists and very few are in private practice" (1964, p. 155).

To further that point, William Perry's classic paper differentiating counseling from psychotherapy was noted as a basis for the claim of uniqueness (1955, p. 157).

From this perspective, a series of conclusions could be drawn, namely that counseling psychology had indeed emerged from its roots (counseling and guidance, vocational guidance and college counseling) was clear as to its mission as a distinctive form of applied psychology.

As to the future, the Report made some predictions, all of which have turned out to be false positives. In the first place, as to size, the prediction was that Counseling Psychology would remain as a "medium-sized" field similar to educational and social psychology but much smaller than either experimental or clinical. Secondly, as to the question of moving toward clinical, the Report kept using the phrase "insist upon its distinctiveness" and as part of that distinction, to coordinate the best school counselor programs with doctoral level counseling psychology training. To further the effort, the report also called for more training in facilities where the differentiated functions of counseling psychology could be performed, universities, schools, rehabilitation centers, et al. "Experiences in hospitals or medical settings, no matter how good, is <u>not</u> a substitute for experience in school settings, college counseling bureaus, community agencies, placement settings, etc." (1964, p. 159). And the final point was to support

broad interdisciplinary study including social science. Also, there was no major call for program APA approval. A review had indicated that only 5 of the top 12 programs were approved. And, overall, there were some 45 programs with less than half on the "approved list". Roger Myers pointed out one major irony, "While in general, the programs in departments of education and educational psychology are flourishing, the parallel programs in departments of psychology are faltering" (Myers 1964, p. 102).

The Current State of the art (or Ark).

Aside from the general feelings of bemusement we all experience in examining historical information from a current perspective, there are a series of important lessons to be drawn as we struggle with the question of the future. It is clear that the world of counseling psychology has undergone a dramatic transformation not only in size but also in training priorities. How is it possible in such a relatively short time for such massive shifts to have taken place? And just look at those shifts.

(1) Size

Currently, there are 47 and 3 (Combined) APA approved programs - more than double the number in 1964. Also, if we include, from

Hollis & Wantz (1986) an estimate of other counseling psychology programs, the number reaches close to 100. Not only are there more programs but more students as well. Fretz predicted, in 1980, it would take until 2001 to reach fifty programs. (Fretz 1980, p. 105). As a result, the biggest increase in doctorate "production' in all of APA is now from the combination of counseling, clinical and school psychology. By 1984, those three fields represented 54% of all new doctorates with the lion's share from the first two (Howard, et al. 1986, p. 1312).

(2) Focus

An analysis of program content indicated that the biggest increase in doctorate programs in the three allied fields were from programs "adhering to the practitioner model" (Howard, et al. 1986, p. 1313).

(3) Quality

The largest increase in doctoral production were from Psychology departments not in the top quartile of national quality. The increase is from "lesser ranked or unranked "programs, a trend the recent report termed as

"worrisome" (Howard, et al. 1986, p. 1315)*.

A series of rhetorical questions now must be asked. Why would a medium-sized field explode? Why would counseling psychology programs, the brain child of major theorists-researchers, shift to a practitioner model? Why would programs originally housed in leading academic departments find that their new colleague programs are from lesser known or unranked departments? As a behavioral scientist, I am certainly aware that all behavior is over-determined yet from my perspective, I see only one major determinant of such a major transformation, private practice and third party payment. In short, counseling psychology with an accelerating frequency has moved more and more to the politics of private practice. What started as a minor drift in the 1970's has now become a full fledged flight. Programs have literally abandoned their earlier interests in areas such as schools, colleges, and non-project public agencies. The rush for third party reimbursement is on. The difficulty is that we are

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*And to add to the problem of numbers, focus and quality, the largest growth in the American Association of Counseling and Development (née APGA) has come in the Mental Health counselors division. Guess what that group is clamoring for? Not primary prevention.

obviously not the only group of psychologists or indeed professional helpers to be aware of the gold of third party payment. And indeed if Cummings (1986) is correct, the field is now saturated to the point of overflow. Whatever currency we had as a distinctive field providing unique help to a variety of client populations has been submerged by the private practice orientation. So while many of our professional colleagues have decided to build their programs on the new emphases, the currency has become devalued. Psychotherapists are being turned out in record numbers. This is only as a reminder of the accuracy of Osipow's (1977) "Law". Training in secondary prevention has driven out primary prevention.

Some of us were more than naive years ago when we thought that doctorate programs could maintain a preventive-developmental focus while gradually adding a few courses in psychopathology and then adding a few more experiences in clinical settings and then adding just a little more work in psychiatric diagnosis, and then adding... By that time the remnants of primary prevention were seen as paradigms favored by some faculty but the real program focus was on treatment. Further, the anticipation of therapy training acted to pre-select the graduate school applicant pool. Certain programs might maintain a brave front but it was soon obvious that a developmental proactive thrust

was only of minor interest to the students. The money, the status, and in the short run, the jobs were tailored to white coats.

Some may ask at this point, so what is wrong with the movement toward clinical psychology? Realists are quick to point out (Fitzgerald and Osipow 1986) that counseling psychologists are in fact practitioner oriented and view themselves as engaged psychotherapy. Further to the point, Watkins (1985) has shown recently that there appears to be no difference between the actual career positions of clinical and counseling psychologists. Thus, the result of the re-orientation in training programs, the increase in doctoral production (and eschewing the problem of quality) has been to push the field to the point where distinctiveness has ended. Also, such realists then take the view of recommending acceptance of (in terms of a psychological version of the naturalistic fallacy) what is becomes what ought to be.

"Thus, the time may have come for the merger of clinical, counseling, and school psychology into a broader human services psychology, (Fitzgerald & Osipow 1986, p. 43).

The Gains and the losses: Following in the wrong footsteps?

Since the gains from such a merger are clearly obvious, namely, near equal status with clinical

psychology, I shall not detail them. As long as the treatment of choice is psychotherapy, then there is little doubt by virtue of history and position that clinical psychology has always been one step up compared to either counseling or school psychology. Since clinical accepted the medical model shortly after World War II, psychotherapy and intra-psychic personality assessment has been their turf. Counseling psychology is indeed the new kid on the block. Of course, as an aside, it may be important to note that while we may think of clinical as of a higher status, there are different perspectives. The American Psychiatric Association has an altogether different view. In fact, they are currently engaged in a political-legislative "putsch" to eliminate clinical from parity in third party payment. And, just to keep everything in perspective, within the American Medical Association, psychiatry itself is clearly one of the lowest status fields. Since the medical model is predicated on a hierarchy of status, we do need to understand all the rules of that game. Probably the most cogent and critical statement from within clinical psychology as to the problems created by medicine can be found in Sarason (1981).

"The therapeutic endeavor needs no justification, but when that endeavor becomes nearly all encompassing

in focus and policy, one must suspect not only the crippling role of parochial thinking but also the failure to examine and confront the nature of society itself. A clinical psychology not rooted in a realistic social psychology...is a misdirected clinical psychology" (Sarason 1981, p. 835).

The status question aside, the fundamental loss which the realists apparently accept is the interactive perspective. The isomorphic and intra-psychic medical model world view goes with the territory. We join on their terms and this includes two very major problems, diagnosis and treatment. The counseling psychologist gives up preventive, developmental, and outreach activities for direct access to psychotherapy. We trade our propositions to work between the "Scylla" of diagnosis and the "Charybdis" of intra-psychic treatment. Why such strong words? Look at the record. The Diagnostic Statistical Manual III has no empirical research base. In fact, the psychiatrists virtually excluded clinical psychology from the process (and that was supposed to be the expert knowledge of clinical) from the first two versions, finally relenting and allowing some clinical psychologists to serve as non-voting observers for the third round (Landers 1987).

Through such exclusion, the psychiatrists were able to expand the category system from the original

sixty to well over two hundred eighty brands of mental illness. As Garmezy (1978) has pointed out, there is no justification for such multiplication. There has been no concomitant increase in a research base to justify such an expansion. The other problem is with the labels as such. Having a plethora of mental illnesses means almost any human can be classified as exhibiting some kind of disease. Without belaboring the point, just think of the self-fulfilling prophecy and stigmatic labeling. So much for Scylla. Now to the Charybdis of treatment.

Any careful research analysis of the effectiveness of psychotherapy must raise series doubts as to efficacy. Even the most optimistic and kindly interpretation from Smith and Glass (1977) in their meta-analysis raises more questions than it answers. By lumping all studies, weak and strong, they conclude that there is a 10% improvement compared to controls. That's the good news*. The bad news is that the

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*Upon reviewing these results, one psychologist noted that these findings would end psychotherapy, See Rimland (1979). Also, the continued movement toward the medical practitioner model and the separation of research training is fraught with difficulties. The sad and sadistic history of lobotomies should be a graphic reminder of how practice can go astray.

experience of the therapist has no relation to outcome, nor does the model of therapy. This has been aptly called, "The Do-Do bird" effect from Alice In Wonderland (Stiles, Shapiro & Elliott 1986).

Earlier studies such as Bergin (1963), Volsky et. al. (1965) had routinely found no positive effects at all between controls and experimentals. A most interesting recent study by Strupp and Hadley (1979) in fact, found no difference in a college counseling center between experienced psychotherapists and "garden variety" untrained academic professors.

From this view, then there are two major drawbacks to the realist's view; The medical model twins of diagnosis and treatment. If we are willing to exchange our identities as behavioral scientists and become medical practitioners, then such a merger makes sense. Are such losses worth the gains? Before answering such a question, there is one final loss which can be predicted?

The most common argument heard in favor of our new identity as psychotherapist is the market-place issue. And certainly it has always been true that economic consideration drive medical treatment and by association have driven traditional intra-psychic treatment, whether it be in the form of YAVIS as a purchase of friendship (Schofield 1964) for the rich

and well-born. Thus, the market place has dictated the major consideration in our present focus. After all, the vast numbers of new graduates have to find employment. However, what the market-place gives, the market-place takes away. The competition for the medical dollar increases and as cost containment becomes more and more necessary, the gold of third party payment will turn into a fools gold. My prediction is based on a number of factors. In the long run, the public will eventually know about the problematic, yet expensive cure rates. Also, in the long run, the health maintenance organizations will shift to short-term treatment by masters level practitioners under doctoral supervision. As that happens, the insurers themselves will gradually reduce their willingness to pay huge treatment fees, furthering a shift to cost effective (cheaper) treatment. In accounting, there is a system of inventory control called LIFO, last in first out. Guess who will be last in and first out for access to parity reimbursement?

An Alternative Identity

While obviously calling for a return to our roots in schools, colleges, and career development centers, do I have anything else to offer besides nostalgia as a basis for identity? There is a long answer and a short. For my purpose, I shall choose the second.

While counseling psychology has been moving toward clinical, what else has been going on as a basis for a distinctive identity? From my view, of course, the major increase in both basic and applied studies from a cognitive-developmental framework has been of major significance. The research base for the major assumptions has increased at an exponential rate. We have a clearer picture of stage, sequence, and domains. So from Piaget (1970), David Hunt (1974), William Perry (1970), and Patricia Arlin (1975), we know more about the sequence of conceptual thoughts as to how humans make meaning from experience. From Dupont (1978) and Selman (1980), we learn about stages of emotional growth. From Loevinger (1977), a framework for ego/self development is apparent. From Super (1985) and Heath (1977), we have learned about stages of career development. From Kohlberg (1984) and Rest (1986), the picture of value judgment is outlined. This means we have the outlines of a general theory for proactive development. In the "old" days, we rationalized. We studied abnormal psychology in order to illuminate the normal. Now we study the normal. While each developmental theorist has critics. My point is that on an overall basis, examining all the research and theory from all these domains, we now have a clearer successive approximation as to how humans grow and develop than that of any competing paradigm.

The second point is that programs and/or treatments tied to the developmental model have also been increasing during this same twenty year period. Also, in my view, the major shift in behaviorism from operant conditioning to the current paradigm which includes the concepts of "inner behaviors" and "self" management means that a theoretical bridge is now possible between the developmental and the new behavioral model, abridge which can promote a wide variety of programs and educative interventions in the service of human growth.

Examples of the deliberate developmental model can be found at all levels. I shall simply cite a few to illustrate the point. Elementary schools, (Gerler & Anderson 1986), Secondary schools, (Sprinthall 1980), Schools within-a-school, (Mosher 1979) and programs for juvenile delinquents (Niles 1986). At a more general level, there are value development programs (Rest 1986), Social skills training (Gazda & Pistole 1986), and developmental counseling (Blocher 1987, Ivy 1987, and D'Andrea 1984). At the college level, the work of Widick, Knefelkamp & Parker (1975), Whiteley's program in college dormitories (1982), Welfel's program for career development (1982), Drum's ideas for counseling centers (1984) and Mentkowski's (1984) program for an entire college community, all stand as exemplars of a preventive approach. The recent work of

Thies-Sprinthall (1984 & 1986) is an example of applied developmental theory for beginning and in-service teachers. Finally, Scharf et. al (1983) points out roles and strategies in working with adult prisoners. So, we don't have to look very far to find programs in educative and public service, versus medical, which promote growth*.

In the self-management behavioral interventions, the work of Thoresen & Coates (1978) represents a major breakthrough. It would, unfortunately, require two much space to outline the new synthesis which has implications for practice. That will be the task of a forthcoming paper. In the meantime, however, and perhaps ironically, while counseling psychology has drifted toward clinical, this has been a period of remarkable research and theory for applied program development which points in exactly the opposite direction. Rather than pathology, we have a promising multi-dimensional theory of growth. Rather than new techniques for readjusting the intra-physic balance, we have some methods which promote that growth.

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*Not so incidentally, I was pleased to receive important commentary to my letter to the Division 17 Newsletter from Larry Brammer, George Gazda, Norman Kagan and Arthur Horne. See "Kudos to Don Blocher" (1986), 17 Newsletter, 7, 3.

Also, and in my view, most important of all, is that the focus of the developmental model is genuinely interactive. This means we avoid in Al Ivey's terms the "Parsonian error" (Ivey 1970). This also means that the growth model does not assume the difficulty is within the skin of the person but rather we maintain an equal concern with the environment. For example, in dealing with ethnic minority groups and women, if the problem is (as is usually the case) racism or sexism then the counseling psychologist takes on the causes and does not treat the symptoms. This would include setting up non-profit public agencies such as Women's Centers, Centers to Eliminate Racism, etc. Paraprofessionals and volunteers can be trained as lay helpers and lay advocates to promote the public welfare. In the Lewis & Lewis (1983) model proactive advocacy to change the rules, laws and conventions of oppression are central, versus "adjusting" the client to accept the devalued position which the majority society condescending sets aside.

George Albee (1982) has shown the limits of the conventional approaches and has pointed out the professional barriers which prevent prevention. I think or at least I hope there is still some strain of altruism in counseling psychology to take on these larger issues. There is certainly a need in schools,

colleges and non-profit agencies for such proactivity lead by developmentally oriented psychologists.

Albee says:

> Support for a primary prevention alternative derives from (a) the successful application of public health methods in promoting population health; (b) a growing body of research literature that demonstrates the role of poverty, meaningless work, unemployment, racism and sexism in producing psychopathology; and (c) the effectiveness of programs promoting social competence, self esteem, and social support networks in reducing psychopathology (1982, p. 1043).

Implications for Training: The Two-Thirds Rule

If we are willing to support a distinctive identity based on the broad concepts I have outlined, then the setting for training is derivative. In the classic study of medical education, Boys in White (Becker 1961), the point was made. The first two academic years of medical education were almost irrelevant. The identity was formed during the clinical years under the tutelage of the real faculty, the hospital physicians. So too for counseling psychologists. No matter how persuasive is the academic course work, the pre-practicum, practicum,

internship sequence undoubtedly is the crucible for identify resolution. My former colleague, Moy Gunn (1979) summed it up nicely. If the program is to feature a developmental preventive approach then from two-thirds to three-fourths of the training experiences must be in that mode. In a school placement, then most of the work would be in leading actual classes on psychological topics, running workshops for teachers and parents, doing cross-consultation with colleagues, and doing research to assess the effectiveness of planned programs. A small amount of time would be for intensive counseling, either individual or group. Advocacy experiences would include taking on issues such as illegal drug testing, rooting out sexism and racism at the hidden agenda level and dealing with the causes of the epidemic of teen pregnancy.

At the college level, the same would hold; teaching counseling skills to residence hall assistants, mentoring skills to upper-class minority students, reorganizing dormitories as living/learning centers, running value development groups, career planning, time management, study skills, etc. Small amounts of training time would be on individual or

small group intensive counseling.* Advocacy issues could include the exploitation of minority athletes, the date-rape problem; general sexual harassment and safety for females.

At the community level, non-profit agencies providing assistance to the wide variety of devalued groups would be the training sites aimed at preventing domestic violence, drug abuse, sexual exploitation and racism. The programs would include the major focus on training workshops to (with apologies to George Miller) give the secrets of psychology away to the "unwashed", to work with prison parolees, rape victims, companions to bereaved persons, et al.

As is readily apparent, the list at each level is potentially endless. There are genuine human needs, for the most part, unaddressed.

The quality of any civilization can be judged not by how the favored classes fare, but how the devalued groups are treated by all the major socializing

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*In reviewing my notes from the 1986 APA convention, I find that these recommendations actually mirror those of David Drum from the University of Texas. He went Moy Gunn one better. His estimate was 90% out of the office and 10% for individual counseling.

institutions of the society. Are the benefits and burdens equally shared? Not by a long shot. And the current trend toward the increasing privatization of mental health services is in exactly the wrong direction. Thus, the role of the counseling psychologist in training will be to work in sites where the human welfare agenda is maximized and the profit motive minimized, whether it be in schools, colleges, or community agencies. Finally, it is my view that such training in the proportion of at least two-thirds to one-third time on task is a basic requisite.

Primary prevention is easy to say, yet very difficult to do (Sprinthall 1982). The amount of experience from my years of supervision suggest clearly that it takes much longer to be successful in the preventive mode than in more traditional treatment modes. At least it is obvious when you fail. You can't so easily blame the victim as is the case in individual counseling. Also, you have to learn to work in the open, in front of unsophisticated and in some cases unforgiving groups. The social amenities of middle class America are often missing. The counseling psychologist needs to prove that he or she is both genuinely understanding and can provide real help. It is not the kind of work that any professional can do without a major investment of time and supervision. Without that, you can be sure that the

counseling psychologist will simply go through the motion and then slip back to the comfort of secondary prevention. As Ursela Delworth so clearly noted, it has happened before.

"Little has come of the promise that paraprofessionals would create a real change in the delivery of human services especially for minorities, the poor and women (Delworth 1974, p. 336).

The change agent paraprofessionals were simply co-opted by the establishment and the agencies themselves remained as racist, sexist, and elitist as before. The sensitivity to the needs of such devalued groups remained unanswered.

The choice at hand: Promoting human welfare

As I see it now, we have a choice. We can continue the drift, to seek accommodation with clinical psychology and move whole-heartedly into the practitioner and provider of health services model under the aegis of medicine. Such a view strikes me from a broad human welfare perspective as a sell-out. Counseling psychologists, third in line behind psychiatry and clinical psychology, and just ahead of the mental health counselors, and social workers end up seeking to protect in guild-like fashion our

perquisite.* As James March said in a slightly different context that such efforts represent little more than,

> "An excessive concern for career, position, and the petty indulgence of personal pleasure without point or consequence" (March 1975, p. 10).

The alternative is to go back to our roots and add in the growing body of theory and practice evident in the past twenty years. Greystone talked rather proudly of a distinctiveness for counseling psychology. There was wisdom in seeking to build programs and personnel to work in schools, colleges, and non-profit public agencies and avoiding the market place. There was wisdom in leaving therapeutic diagnosis and treatment to others. There is the same wisdom today. Leave therapy to the practitioners, as those ranks are being filled so abundantly by graduates of questionable programs. It's time for us to deal with causes not symptoms and re-direct our efforts toward a distinctive identity as counseling psychologists.

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Fretz, B. (1980). "Counseling psychology: 2001". In J. Whiteley & B. Fretz (Eds.), The present and future of counseling psychology (pp. 105-112). Monterey, CA: Brooks Cole. In fact, reading all the predictions in this book, I found with the exception of Allen and Mosher, most have already proved false. Apparently, very few of this select group saw how strong the clinical movement was. My favorite predictive quote from Mosher is, "Counseling psychology is like the Wizard of Oz at the moment of truth ... Behind the pomp and mystery is one very frail, aging wizard who is fresh out of magic" (1980, p. 125). Allen noted, "Still we have persisted, hungering and thirsting after a licensing arrangement in the image of medicine" (1980, p. 187).

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